

OCCUPATIONAL THERAPY

Assessment planning

Affix client record label here

Reason for referral

Referred by:

Background information

Occupational performance problems (tick all areas of concern)

Personal ADL

- ☐ Showering
- ☐ Grooming
- ☐ Food intake
- ☐ Laundry
- ☐ Medication use

Domestic ADL

- ☐ House cleaning
- ☐ Meal preparation
- ☐ Gardening
- ☐ Laundry
- ☐ Pet care

Community ADL

- ☐ Banking
- ☐ Budgeting
- ☐ Shopping
- ☐ Driving
- ☐ Employment
- ☐ Transport
- ☐ Social

Additional information

- Physical status: _____
- Supports (family, friends, other): _____
- Living situation (private, hostel, boarding...):

- Services (home help, meals on wheels...): _____

Contacts

	Name	Phone	Additional information
GP			
Family			
Other			

Type of OT assessment required

- Full occupational performance assessment and report
- Review and assess only specified areas of occupational performance
- Other: _____